

Authorization to Disclose or Request Protected Health Information

(HIPAA Compliant Authorization Form)

I, _____
Name of Patient (Please Print) *Patient's Date of Birth (mm/dd/yy)* *Patient's Phone Number*
of _____
Patient's Address

hereby authorize the following Service Provider:

Agency: _____

Address: _____

1. To **disclose** individually identifiable health information to and/or **receive** information on my behalf from:

Supervisor or his/her designee *Name*

2. The following specific information is authorized: _____

3. This authorization is in effect for the period of time from _____ to _____
(Date of Event) *(Date of Event)*

4. This authorization allows the indicated service provider to share the specified information for:
A single use or disclosure available at the time of authorization
On-going use or disclosure for the time period identified in Item 3

5. The information will be used/disclosed for the following purpose(s): _____

6. The source records for information disclosure:
ARE protected by federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2) because the records contain information on prior, current, or planned substance abuse treatment. If these records are protected by regulation 42 CFR Part 2, I understand the recipient is prohibited from making any further disclosure of this information unless expressly permitted by my written authorization, except as otherwise permitted within the regulation. 42 CFR Part 2 also restricts any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

ARE NOT protected by federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2). If these records are not protected by 42 CFR Part 2, I understand the Federal Privacy Rule (45 CFR Part 160 and 164, HIPAA) requires I be advised that information used or disclosed based on this authorization may be subject to redisclosure and no longer protected by Federal HIPAA regulations.

7. I understand that:

- Service providers using or disclosing information based on this authorization are to share the minimum necessary amount of the specified information to accomplish the purpose of the disclosure identified in Item 5.
- Wintergreen Rescue Squad will not condition the provision of services related to treatment, payment, enrollment, or eligibility for benefits on my decision to sign this authorization.
- I may revoke (or cancel) this authorization at any time by submitting a written statement of revocation to the service provider whose address is provided above, except to the extent that the identified service provider already has acted based on this authorization.
- I have a right to request and receive a Notice of Privacy Practices from Wintergreen Rescue Squad.
- The information to be released has been fully explained to me and this authorization is given of my own free will.

8. Please send or communicate the authorized information to the following address, phone number, fax number or email address:

Resident Signature: _____ Date: _____

Relationship to patient: Self Parent of Minor Child Guardian Legally Authorized Representative